

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09249

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
 City or town Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 1/2 hrs

Hospital, institution, or street address where death occurred:

Calvert County Hospital

How long in hospital or institution? _____

3. (a) FULL NAME

Infant Bright

4. Sex

Male

5. Color or race

 Negro

6. (b) Single, married, widowed, or divorced

 -

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 19488. AGE: Years Months Days It less than one day
1 3 1/2 hrs. min.9. Birthplace Prince Frederick, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name John Bright13. Birthplace Washington, D.C.MOTHER 14. Maiden name Charlotte Johnson15. Birthplace Montreal, Md.16. Informant Charlotte BrightAddress Island Creek, Md.17. burial Date thereof 9-30-48
(Burial, cremation, or removal. Which? (month) (day) (year))Cemetery or crematory Brooks ChapelLocation Calvert18. Funeral director P. E. SewellAddress Prince Frederick, Md.19. 9-30- 19 48 H. W. Ward
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Island Creek, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 19 48 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____
and that I last saw him alive on 9/28 19 48

Immediate cause of death

congenitalDue to (undetermined)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

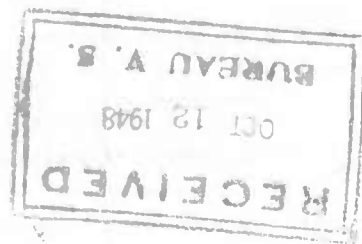
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hessner M. D. or otherAddress Hicklingtown Date signed _____

DURATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09250

Reg. Dist. No. 51

1. PLACE OF DEATH:

County CalvertCity or town Broomes Island
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Broomes Island
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war No

3.(a) FULL NAME

Edie C. Buck

3.(b) Social Security Number

214-20-2573

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

W6.(b) Name of husband or wife Mary R. Buck

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1887

8. AGE: Years Months Days If less than one day

6153

_____ hrs. _____ min.

9. Birthplace Calvert County, Md
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business

12. Name Joseph Buck13. Birthplace Md14. Maiden name Mary Elizabeth Catherine15. Birthplace Md16. Informant Rodney BuckAddress Broomes Island, Md17. Burial Date thereof Sept 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Broomes IslandLocation Broomes Island, Md18. Funeral director A. A. Warkentin & SonAddress Mutual, Md19. 9-7 19 48 N. H. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5, 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 to Sept 5 1948and that I last saw h. _____ alive on Sept 5, 1948

Immediate cause of death _____

DURATION

Respiratory FailureDue to AcidosisDue to Multiple Sclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

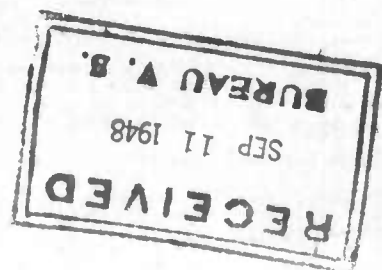
Injured at home, farm, industry, pub'l'c place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE J. B. Sillarney

M. D. or D.O.

Address 58 RemondDate signed 9/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09251

Reg. Dist. No. 52

1. PLACE OF DEATH:

County Calvert

City or town Owings
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Owings
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

CATTERTON, JACK James S.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

About 1871

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

77

_____ hrs. _____ min.

9. Birthplace

Calvert Co, md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Frank Catterton

13. Birthplace

md

MOTHER

14. Maiden name

Eliza Galt

15. Birthplace

md

16. Informant

Mr. Odien Catterton

Address

Owings md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept 12, 48
(month) (day) (year)

Cemetery or crematory

mt Harmony Cem.

Location

Mr. Owings md

18. Funeral director

W. H. Hutchins

Address

Owings, md

19.

(Date rec'd by registrar)

Sept 12, 48

Grace L. Hutchins

Registrar

23. SIGNATURE

H. R. Brashear Jr. mox

M. D. or other

Address

Prince Frederick md

Date signed Sept 13, 48

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 19 48 at _____ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 48 to Sept. 8 19 48
and that I last saw him alive on Sept. 8 19 48

Immediate cause of death

Arteriosclerotic Cardiovascular
Renal Disease

DURATION

years

Due to

Due to

Other conditions

Senile Psychoses

(Include pregnancy within 3 months of death)

Major findings of operations

Partial infarction

Date of op. Feb. 7, 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____



Evidence for change of
birth date shown on:

FILM No. G 11-SEP 30 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09252

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH:

County Calvert

City or town Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Calvert County Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Love Point
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Albert Curry

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Martha Curry

6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1980

8. AGE: Years 67 Months 18 Days 10 If less than one day 2 hrs. _____ min. _____

9. Birthplace Love Point - Calvert Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

FATHER 12. Name Thomas Curry

13. Birthplace Virginia

MOTHER 14. Maiden name Blair Jones

15. Birthplace Maryland

16. Informant Martha Curry

Address Love Point, Md.

17. Burial Date thereof 9-18-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns

Location Calvert

18. Funeral director P. E. Sewell

Address Prince Frederick, Md.

19. 9-9 19 48 H. W. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 19 48, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Acute gangrene

Due to _____

Diabetes

Due to _____

Other conditions Cardiac

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

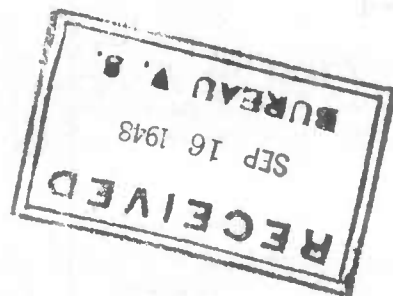
23. SIGNATURE P. E. Sewell M. D. or other _____

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 19-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09253

FILM No. G 117 SEP 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CalvertCity or town Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Myrtle B. Gibson

3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lloyd Gibson6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) 29 Sept 18928. AGE: Years 55 Months 11 Days _____ If less than one day _____ hrs. _____ min.8. Birthplace Lower Marlboro
(Town, county, and state)

10. Usual occupation _____

11. Industry or business Home12. Name Sam D. Cox13. Birthplace MD14. Maiden name Sarah E. Ward15. Birthplace MD16. Informant Lloyd GibsonAddress Lower Marlboro17. Burial Date thereof Sept 15 1948
(Burial, cremation, or removal. Which? (month) (day) (year)Cemetery or crematory CemeteryLocation Lower Marlboro Md.18. Funeral director William H. HutchinsAddress Owings Md.19. Sept 13 19 48 Elsie M. Cox
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 19 48 at 1:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Aug 19 48 to 9/12 19 48and that I last saw her alive on 9/11 19 48Immediate cause of death Ca 7 Melanoma

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

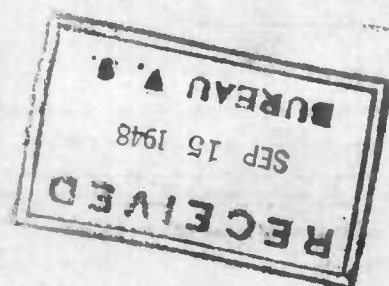
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or D.D.Address Huntingtown MD Date signed 9/13/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County Calvert
City or town Wallville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Calvert
City or town Wallville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John F. Gross.

3. (b) Social Security Number

4. Sex m 5. Color or race C 6.(a) Single, married, widowed, or divorced X
6.(b) Name of husband or wife Maggie A. Gross.
7. Birth date of deceased (mo., day, yr.) 12-12-1871
6.(c) If alive, give age 60 years
8. AGE: Years 96 Months Days If less than one day hrs. min.

9. Birthplace md
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business
12. Name William Gross.
13. Birthplace md
14. Maiden name Charalott Johnson
15. Birthplace md.

16. Informant Maggie A. Gross.
Address Wallville
17. Burial Date thereof 9-25-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brooks Chapel
Calvert
Location
18. Funeral director P.F. Sewell
Address Bruce Frederick Mfg
19. 9-28 19-48 Hewward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1948 at 12³⁰ PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Sept 22 1948
and that I last saw him alive on Sept 22 1948

Immediate cause of death
Acidosis
Due to Hypertension c.v.d.
Due to Generalized arteriosclerosis
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE St. Leonard M. D. or other
Address St. Leonard, Md. Date signed Sept 24/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

09255

1700

1. PLACE OF DEATH:

County..... Calvert MD
 City or town..... Prince Frederick md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town..... Owings md
 (If outside city or town limits, write RURAL and give nearest town)Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Carroll Edward Hicks

3. (b) Social Security Number

218-24-1158

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

X

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

July 14, 1927

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

21

hrs.

min.

9. Birthplace..... md

(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business.....

MOTHER FATHER

12. Name.....

Benjamin Hicks

13. Birthplace.....

md

14. Maiden name.....

Saura Jacks

15. Birthplace.....

md

16. Informant.....

Benjamin Hicks

Address.....

Owings md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

9-22-48
 (month) (day) (year)

Cemetery or crematory.....

St. Johns

Location.....

Calvert, Lower Marlboro

18. Funeral director.....

P.E. Sewell

Address.....

Prince Frederick md19. 9-21

(Date rec'd by registrar)

19. 48H.W. Ware

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 9-20, 1948, at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him alive on.....19.....

Immediate cause of death.....

fractured skull

DURATION

4 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 9/20/48Where did injury occur? Chesapeake Calvert Mts
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury car accident injured at work? no

23. SIGNATURE.....

H.W. Ware

M. D. or other

Address..... Date signed.....

RECEIVED

SEP 28 1948

BUREAU V. S.

~~Birth~~ Death
 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 51

A certificate must be filed within 24 hours for every stillbirth of 20 weeks gestation or more (see stub)

1. PLACE OF BIRTH:

County Calvert
 City or town Prince Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Calvert County Hospital
 Length of mother's stay in County.....
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Calvert
 City or town Broomes Island
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If RURAL give LOCATION)

3. Name of child.....

5. Sex male

6. Twin or triplet.....

4. Date of birth Sept 26 1948 Hour..... M.

7. No. of weeks pregnancy.....

FATHER OF CHILD

8. Full name James Briscoe Parks
 9. Color white 10. Age at time of this birth 34 yrs.
 11. Usual occupation gyster mal

MOTHER OF CHILD

12. Full maiden name Maida Louise Fowler
 13. Color white 14. Age at time of this birth 26 yrs.
 15. Usual occupation Housework

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 7
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor?..... During labor?.....

18. Pregnancy, complications of.....

19. Labor: (a) Complications of.....

(b) Induced?.....

20. (a) Was there an operation for delivery?.....

(b) State all operations, if any..... (Yes or No)

(c) Did child die before operation?.....

During operation?.....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes.....

(b) Maternal causes.....

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature [Signature]
 (Specify if M. D., midwife, or other)

Address.....

23. (a) burial (b) Date thereof 9-27-48
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Broomes Island

24. (a) Funeral director Business Parks

(b) Address Broomes Island, Md

25. (a) 9-27-48 (b) H. H. Hale
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

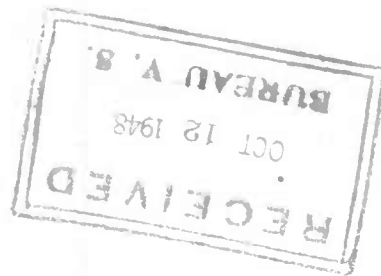
V. S. A10

Child died 2 hrs.

M

I

T



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09256

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
City or town Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Calvert
City or town Oroving
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

WINFIELD Falls Vande (SMITH)

3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced S

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1948, at 5:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw h. _____ alive on _____ 19____

Immediate cause of death Thrombosis

DURATION

5 day

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Howard

M. D. or other

Address Oroving MD Date signed 9/20/48

11. Industry or business

Doctor Falls Vande Jr

12. Name

Va

13. Birthplace

Henneretta Smith

14. Maiden name

MD

15. Birthplace

Clement Smith

16. Informant

Oroving

Address

Howard Date thereof Sept 21 1948

(Burial, cremation, or removal) Which?

Cemetery or crematory Wt Hope

Location Howard

18. Funeral director

R C Smith

Address

Oroving MD

Sept 20 48 Howard

19. (Date rec'd by registrar)

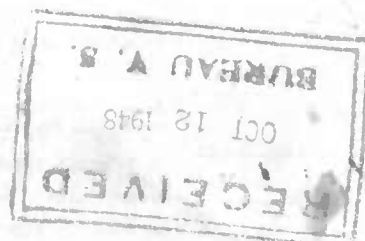
Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09257

Reg. Dist. No. 52

1. PLACE OF DEATH:

County CalvertCity or town Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Calvert County HospitalHow long in hospital or institution? 4 Days

3. (a) FULL NAME

Joseph Herbert Ward4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mrs Eva Ward7. Birth date of deceased (mo., day, yr.) Aug 29, 1885 5. (c) If alive, give age 54 years8. AGE: Years 63 Months 27 Days 27 If less than one day hrs. min.9. Birthplace Calvert Co Md
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Mr John C Ward13. Birthplace Md.14. Maiden name Miss — Howard

15. Birthplace

16. Informant Mrs Eva WardAddress Dwings Md.17. Burial Date thereof Sept 27/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory FriendshipLocation Friendship C.P. Co18. Funeral director Wm A. HutchinsAddress Dwings Md.19. Sept 26 19 48 Grace L Hutchins
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CalvertCity or town Dwings Md
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 19 48 at 4 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Mar 19 48 to 9/25 19 48and that I last saw him alive on 9/24 19 48Immediate cause of death Cerebral hemorrhage

DURATION

Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Wm A Hutchins M. D. or DrAddress Huntingtown Date signed 9/24/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

